

ADULT PATIENT INFORMATION

Please complete the **FRONT** and **BACK** of this form and return to the receptionist. Thank you!

Personal Information

Today's Date: _____

Name: _____ Birth date: _____ Sex: Male Female

Preferred to be Called: _____ Age: _____ Marital Status: Married/Single/Other

Address: _____ Spouse's Name: _____ No. of Children: _____

City State Zip Your Social Security No.: _____

Your Driver's License No.: _____

Home Phone () _____ Work Phone () _____
Employer: _____

Cell Phone () _____ Other Phone () _____
Employer's Address: _____

Head of Household: _____ City State Zip
(This is for billing purposes. Party responsible for family account)

In Case of Emergency, Contact: _____ Contact Phone #: _____

Contact Relationship to Patient: _____

E-mail and Special Offers

Would you like to be added to our e-mail directory to receive special offers and monthly newsletters? YES NO

If yes, please list your e-mail address: _____

Medical/Dental Information

Name of Family Physician: _____ How is your health? Excellent Good Fair Poor

Physician's Address: _____ Physician's Phone No.: _____

Previous Dentist's Name: _____ Previous Dentist's Phone No.: _____

Do you have, or have you ever had, ANY of the following? Please circle all that apply:

AIDS/HIV Positive	Diabetes	Hepatitis B	Rheumatic Fever
Alcoholism	Drug Addiction	Hepatitis C	Rheumatism
Anemia	Emphysema	High Blood Pressure	Scarlet Fever
Angina Pectoris	Epilepsy or Seizures	Kidney Trouble	Sickle Cell Anemia
Artificial Joint	Fainting or Dizzy Spells	Latex Allergy	Sinusitis
Artificial Heart Valve	Glaucoma	Learning or Speech Disorder	Stroke
Asthma	Hayfever	Liver Disease	Thyroid Disease
Blood Transfusion	Heart Surgery	Mitral Valve Prolapse	Tuberculosis
Bruise Easily	Heart Failure	Nervousness	Ulcers
Chemotherapy	Heart Disease or Attack	Pacemaker	Venereal Disease
Cold Sores	Heart Murmur	Pain in Jaw Joints	X-Ray/Radiation Treatmt
Congenital Heart Lesion	Hemophilia	Psychiatric Treatment	Yellow Jaundice
Cortisone Medication	Hepatitis A	Radiation Therapy	

Any other Illness: _____

Surgeries: _____

List any Allergies (medications or other): _____

Please answer YES or NO to the Following Questions:

- ❖ Are you having any pain or discomfort at this time? _____ YES NO
- ❖ Do you feel nervous about dental treatment? _____ YES NO
- ❖ Have you ever been upset about any dental work you have received? _____ YES NO
- ❖ Have you changed dentists frequently? If yes, how often? _____ YES NO
- ❖ Have you been a patient in the hospital during the last two years? _____ YES NO
- ❖ Are you currently under the care of a physician? _____ YES NO
- ❖ Are you currently taking any medications? If yes, specify. _____ YES NO
- ❖ Have you ever had any excessive bleeding requiring special treatment? _____ YES NO
- ❖ Have you ever experienced growths or sore spots in your mouth? _____ YES NO
- ❖ Have you had any allergic reactions or allergic symptoms to local or general anesthetics? _____ YES NO
- ❖ Have you ever had difficulty with extractions in the past? _____ YES NO
- ❖ Do your gums bleed with you brush or floss? _____ YES NO
- ❖ Do you habitually clench or grind your teeth? _____ YES NO
- ❖ Do you smoke? _____ YES NO
- ❖ Do you have any disease, conditions or allergies not listed? _____ YES NO

Women Only

- ❖ Are you pregnant? _____ YES NO
- ❖ Are you practicing birth control? _____ YES NO
- ❖ Do you anticipate becoming pregnant in the near future? _____ YES NO

Dental Insurance Information

Name of Insurance Company: _____ Phone No.: _____

Name of Policyholder: _____ Policyholder's SSN: _____

Patient's Relationship to Policyholder: Self/Spouse/Child/Other: _____ Policyholder's DOB: _____

Employer's Name Providing Insurance: _____ Group No.: _____

I authorize the assignment of my insurance benefits to DENTAL INNOVATIONS.

Patient's Signature: _____ Date: _____

Referral Information

How were you referred to our office? Please circle all that apply.

- | | |
|--|---|
| Insurance Company | Yellow Pages: JO CO SWB FEIST/Yellow Bk |
| Friend (Please list their name: _____) | Internet Ad/Family Dental Website |
| Cosmetic Postcard | Walk In |
| Dental Office Employee (Please list name: _____) | Val-Pak Offer |
| Other (Please list: _____) | Drive By |

Treatment Authorization and Acknowledgement

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, or treatment of dental emergency. These procedures may include radiographs, models or intra-oral examination. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor understanding that the procedures will be explained in advance. I give consent to the use of local anesthetic for completing the necessary dental treatment.

I also understand that **PAYMENT IS DUE AT THE TIME OF TREATMENT.**

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICY.

Patient, Parent, or Legal Guardian

Date

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

DENTAL INNOVATIONS, P.A.

11221 Shawnee Mission Pwky Shawnee, KS 66204
(913) 236-8899

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Date: _____

Signature: _____

(If patient is under 18, Parent or Guardian Signature)

Relationship to Patient if Minor

Dependent family members also covered by this acknowledgement:

I authorize the following individual(s)/parties to receive information or inquire about my dental treatment:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Emergency situation
- Communication barriers
- Other

Dental Innovations, P.A.
Policies, Procedures and Authorizations

The dentists and staff at Dental Innovations, P.A. strives to offer comprehensive, quality dental care to all of our patients. We feel that it is appropriate to inform our patients in advance of the policies, procedures and authorizations required at Dental Innovations that may ultimately affect their care. Please read the following policies, procedures and authorizations carefully and initial after each. Please sign and date your understanding at the end of this form. If you are a patient under the age of 18, your responsible party must also read and sign this form.

Cash Accounts

I am responsible, at the time of service, for all expenses incurred during my office visit. Dental Innovations accepts cash, checks, money orders, MasterCard, Visa, American Express and Discover credit cards. Initials _____

Care Credit

Dental Innovations does accept Care Credit credit cards from those patients who are not on a Preferred Provider Plan. Initials _____

Insurance Co-Pays

My co-pay is due at the time I check in for my appointment. If I do not have my co-pay, I will be asked to reschedule my appointment. Initials _____

Non-covered Services

Non-covered services will need to be paid at the time of service. I understand that I am responsible for checking my benefits with my insurance carrier before my appointment time. Initials _____

Returned Check Fees

I understand that if Dental Innovations receives a returned check written by me or on my behalf, I will be charged a returned check fee of \$35.00 and will be required to pay cash or use a credit card for any future payments. Failure to repay the returned check and the returned check fee may result in collection proceedings or dismissal as a patient from Dental Innovations. Initials _____

Account Interest

As a courtesy, Dental Innovations will file my charges associated with my dental visit to my insurance plan. I understand that my account balance must be paid within 60 days of my dental visit even if the insurance company has not paid their estimated portion. Account interest will be calculated each month on the amount of the unpaid balance (referred to as Previous Balance). After 60 days I will be charged at a rate of 18% per annum and charged on a monthly basis. Initials _____

Collection Process

Any balance that remains unpaid after 90 days will be turned over to collections if timely satisfactory payment arrangements have not been established. I understand that I will receive a letter from Dental Innovations notifying me that I have a certain date to respond and if I do not respond, my account will be turned over to an outside collection agency. I further understand that I will be obligated to pay for any collection fees, reasonable attorney fees and court costs should the collection proceedings advance to litigation. If my account is turned over to the collection agency, I will not be allowed to schedule any further appointments with Dental Innovations or seek dental advice of any kind until my account has been paid in full. Initials _____

Missed Appointments

I understand that Dental Innovations may, but is not required to, call my home to confirm my upcoming appointment date and time. I understand that this is a courtesy and that I am ultimately responsible to keep my dental appointment. I understand that Dental Innovations may charge a \$50.00 missed appointment fee for appointments missed and not changed or cancelled within 24 hours prior to my scheduled appointment. Initials _____

After Hours Phone Calls

Dental care providers should only be called or paged after normal business hours for serious dental concerns. In the event of a true dental emergency, I should call 911 or go to my nearest emergency room. Dental Innovations' normal business hours are Monday thru Thursday 8 a.m. to 5 p.m. and Friday 8 a.m. to noon. If our dental care providers are excessively paged after hours (more than four times in a 12 hour period), a charge of \$25.00 may apply. Initials _____

Medical Records Release

Dental Innovations will only release dental records when a valid HIPAA compliant authorization is received. Due to increasing costs of office supplies, equipment and postage, Dental Innovations will assess appropriate fees for the copying and mailing of dental records. Initials _____

Discharge of a Patient

I understand that Dental Innovations has the right to discharge any patient from this practice at anytime for various reasons, including but not limited to, failure to abide by Dental Innovations financial policies, noncompliance with recommended treatment plans, drug-seeking activity and any abuse of Dental Innovations staff. If this occurs, I understand that my dental records will be released to another dental office of my choice only after an appropriately signed authorization is received by Dental Innovations. I further understand once discharged from Dental Innovations, I will not be allowed to return as a patient in the future. Initials _____

Final Costs of Services

I understand that I may inquire about costs of services and I will be given a treatment plan informing me the cost of each procedure. I also understand that any patient portion given, when taking into consideration my insurance, is only an estimate. I also understand that at any time during treatment my treatment plan may change due to various reasons such as the decay going deeper into the tooth, the tooth may not be able to be saved, another condition may develop when working on the tooth, etc. Dental Innovations will keep me up to date as conditions change and I will be given an updated treatment plan informing me of the fees.

Initials _____

Dental Innovations Insurance Policy

Dental Innovations participates with over 500 insurance plans and it is my responsibility to choose a dentist that participates with my insurance plan. It is my responsibility to contact my insurance carrier for a list of participating dental care providers. If I choose to have a Dental Innovations dental provider treat me outside of my network, I will be responsible for all charges denied or reduced by my insurance plan. A current insurance identification card is required at each visit. **If I am unable to provide an identification card, I will be required to pay for my treatment AT THE TIME OF SERVICE.** I am also responsible for informing Dental Innovations if my insurance policy has changed. In the event that claims are denied for timely filing and a new insurance card was not provided by me, I will then be responsible for those charges. **Please note: Your insurance policy is a contract between you and the insurance company.**

I am ultimately responsible for all charges incurred at Dental Innovations. It is my responsibility to know the benefits and provisions of my insurance policy. Dental Innovations handles over 500 different insurance plans and only knows the basics of each plan. If I have any questions or concerns regarding the benefits of my policy, I should contact my insurance company directly. If I need to know exactly what the insurance company will cover, I will ask Dental Innovations to submit a pre-determination **BEFORE** I start my treatment. I understand that Dental Innovations can only give me an **ESTIMATED** amount when it comes to my portion that is due for my dental treatment.

If I elect to pay for my services in full, I understand that I can receive a 5% discount if I am not on a Preferred Provider plan. If I ask that Dental Innovations file my insurance portion, I will be required to fill out a credit card authorization form to cover any amount the insurance company does not pay within 60 days. Dental Innovations will call me first to let me know what the balance of my account is before charging anything to my credit card. Once my account is paid in full, Dental Innovations will shred my credit card authorization.

I hereby authorize Dental Innovations to submit a claim and to furnish complete information to my insurance carrier for all services rendered to me by my dentist and authorize and direct my insurance carrier to issue payment on my behalf to Dental Innovations.

Initials _____

Authorization for Treatment

While I am here, I permit the dentists, Dental Innovations staff and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the dentist, will explain my condition and his/her recommended treatment. I also understand that he/she will explain possible ways this condition may be treated. I further understand that no guarantees can or will be made regarding the outcome of this care.

Initials _____

I HAVE READ AND UNDERSTAND THE POLICIES, PROCEDURES AND AUTHORIZATIONS OF DENTAL INNOVATIONS, P.A.

Please print patient's name: _____

Patient Signature

Date

If patient is less than 18 years of age:

Please print responsible party name: _____

Responsible Party Signature

Date

Relationship to Patient: _____